

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No. 1002 Registrar's No.

9950937

STATE FILE NUMBER

FILED JAN 17 1964

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City		Length of stay in 1b 2 months	c. CITY OR TOWN Orrick Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Zilpha Middle Jane Last Williams		4. DATE OF DEATH Month December Day 25 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/26/90
9. AGE (last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Orrick, Missouri	
11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Hiram M. Sharp		13b. MOTHER'S MAIDEN NAME Tryphosa Ellen Bogart	
14. NAME OF HUSBAND OR WIFE Fred Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Pearl Shultz, Independence, Mo.	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 days 2 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			20c. TIME OF INJURY Hour 7:30 a.m. PM Month, Day, Year 11/19/63
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY Mo STATE Mo	
21. I attended the deceased from 11/19/63 to 12/25/63 and last saw her alive on 12/24/63 Death occurred at 7:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Barrett Wilhelm, MD		22b. ADDRESS Kansas City	
22c. DATE SIGNED 12/27/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Dec. 28, 1963		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION (City, town, or county) Orrick		23e. STATE Missouri	
24. FUNERAL DIRECTOR Gowing Funeral Home		25. DATE RECD. BY LOCAL REG. 12-30-63	
26. REGISTRAR'S SIGNATURE Bessie Smith			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Warren F. Wilhelm MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Murray Wilson

Licensed Embalmer No.

4289

P. O. Address

K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.